

**Retain or Reassign Slot  
Of Individual Not Currently Receiving Waiver Services**

Check one: ☐ MR Waiver Slot ☐ DS Waiver Slot ☐ Facility Slot ☐ FY07 Children's Slot

Date of Request \_\_\_\_\_ Check one: ☐ Retain Slot ☐ Reassign Slot

CSB \_\_\_\_\_

CSB Contact \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Individual \_\_\_\_\_

Medicaid No. \_\_\_\_\_

Check one: ☐ Services not yet initiated Date of enrollment: \_\_\_\_\_

☐ Services interrupted Date services were interrupted: \_\_\_\_\_

**Indicate reason below:**

- ☐ No provider available.
- ☐ No provider chosen by the individual.
- ☐ Chosen provider is not currently able to provide services.
- ☐ Medical leave or placement/hospitalization for physical treatment.
- ☐ Placement/hospitalization for behavioral or mental health treatment.
- ☐ Provider no longer able to provide services.
- ☐ Individual (or family/caregiver) has chosen to discontinue services from provider.
- ☐ Individual died.
- ☐ Individual moved out of state.
- ☐ Individual declined waiver services.
- ☐ Individual incarcerated.
- ☐ Other (please describe): \_\_\_\_\_

Explain the above situation & actions taken: \_\_\_\_\_

Date of anticipated service start: \_\_\_\_\_ (if retaining slot)

\_\_\_\_\_  
Signature of MR Director

\_\_\_\_\_  
Date

**OMR USE ONLY**

Based upon the CSB recommendation:

\_\_\_\_\_ The slot may remain with the current individual for another 30 days.

\_\_\_\_\_ The MR Waiver slot may be reassigned by the CSB to another individual meeting urgent criteria, following exhaustion of appeal rights.

\_\_\_\_\_ The CSB may discharge the individual from the \_\_\_\_ DS Waiver \_\_\_\_ MRW facility slot (occupied less than 24 mos.) \_\_\_\_ FY07 Children's slot and must issue appeal rights. If the individual is not appealing or after appeal rights are exhausted, the CSB must notify Central Office of the return of this slot to DMHMRSAS by submission of a Slot Change/New Assignment Fax Cover (DMH 885E 1202) and a DMAS-122 terminating the individual.

\_\_\_\_\_ More information is needed as specified: \_\_\_\_\_

\_\_\_\_\_  
OMR Representative

\_\_\_\_\_  
Date

**Confidentiality Statement:** This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.